DOCUMENT RESUME

ED 449 598 EC 308 204

| | |
|---|---|
| AUTHOR | Gregg, Soleil |
| TITLE | At a Glance: ADHD and IDEA 1997. A Guide for State and Local Policymakers. Policy Briefs. |
| INSTITUTION | Appalachia Educational Lab., Charleston, WV. |
| SPONS AGENCY | Office of Educational Research and Improvement (ED), Washington, DC. |
| PUB DATE | 2000-07-00 |
| NOTE | 13p. |
| CONTRACT | RJ96006001 |
| AVAILABLE FROM | Appalachia Educational Lab., PO Box 1348, Charleston, WV 25325-1348; Tel: 304-347-0400 (Voice); Tel: 800-624-9120 (Toll Free); Fax: 304-347-0487; e-mail: aelinfo@ael.org; Web site: http://www.ael.org. |
| PUB TYPE | Information Analyses (070) -- Legal/Legislative/Regulatory Materials (090) |
| EDRS PRICE | MF01/PC01 Plus Postage. |
| DESCRIPTORS | *Attention Deficit Disorders; Disability Identification; *Educational Legislation; *Educational Policy; Elementary Secondary Education; *Eligibility; Federal Legislation; Government School Relationship; *Hyperactivity; State Departments of Education; State Government |
| IDENTIFIERS | *Individuals with Disabilities Educ Act Amend 1997 |

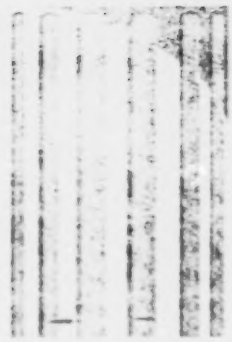
ABSTRACT

This policy brief summarizes the literature and identifies responsibilities of state and local policymakers in meeting legal obligations to provide educational services for students with attention deficit hyperactivity disorder (ADHD) under the Individuals with Disabilities Education Act (IDEA). Presented in a general question-and-answer format, the brief considers the following topics: what ADHD is and characteristics of the child with ADHD; eligibility of children with ADHD under IDEA; responsibility of state education agencies for overseeing school compliance with IDEA; responsibilities of public agencies (i.e., school systems) in meeting the educational needs of children with ADHD under IDEA (10 responsibilities are discussed); and effects of changes to IDEA on children with ADHD living in Kentucky, Tennessee, Virginia, and West Virginia. Tables provide detailed information on diagnostic criteria for subtypes of ADHD, state eligibility requirements, and number and change in number of children served under IDEA, Part B, in the four states listed above. Also listed are additional resources, contacts, and Web sites. (Contains 62 references.) (DB)

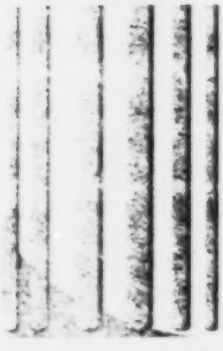
Reproductions supplied by EDRS are the best that can be made
from the original document.

U.S. DEPARTMENT OF EDUCATION
Office of Educational Research and Improvement
EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)
☐ This document has been reproduced as received from the person or organization originating it.
☐ Minor changes have been made to improve reproduction quality.
• Points of view or opinions stated in this document do not necessarily represent official OERI position or policy.

ED 449 598



Policy Brief



# At a Glance: ADHD and IDEA 1997

## A Guide for State and Local Policymakers

Attention-Deficit/Hyperactivity Disorder (ADHD or ADD*) sprang into public consciousness a few years ago and has gotten so much media play that some now dismiss its seriousness, thinking it's a fad diagnosis or an excuse for bad behavior. Recent medical research, however, has confirmed the validity of the diagnosis and has begun to reveal the disorder's biological, genetic, and neuropsychological underpinnings.[1,2,3,4,5] Despite growing public awareness and scientific knowledge, children with ADHD do not always get the academic and behavioral help they need to succeed in school.

Research shows that appropriate, comprehensive intervention and treatment can help children with ADHD achieve success.[1,6,7,8,9,10,11,12,13] In fact, schools are legally obligated to locate and evaluate all children suspected of having disabilities—including children who may need special education and related services because of their ADHD. For those determined to be eligible for services, schools must provide appropriate special education and related services to meet their unique needs.[14,15] The 1997 Amendments to the Individuals with Disabilities Education Act (IDEA) not only guarantee the right to a free appropriate public education for children with disabilities, but, if implemented as intended, can provide the level of support that children with ADHD need to succeed in school.

Because state and local policymakers share oversight responsibility for public

*The American Psychiatric Association currently uses the term Attention-Deficit/Hyperactivity Disorder (ADHD) rather than Attention Deficit Disorder (ADD) for all types of the disorder—even the Predominantly Inattentive Type not characterized by hyperactivity. To avoid confusion, the federal regulations implementing IDEA include both terms, ADHD and ADD. In this document, one term—ADHD—is used to mean all types and/or versions of the disorder.



EC 308 204

BEST COPY AVAILABLE

education in their respective states and districts, they must ensure that schools meet legal obligations to make a free appropriate public education available to students with ADHD who are eligible for services under IDEA. In addition, IDEA's new focus on accountability and results—especially within the context of a state's high-stakes accountability system–provides policymakers an extra incentive to see that schools help children with ADHD meet state and district performance standards.

## What is ADHD?

ADHD is a highly hereditary, neurobiological disorder characterized by **age-inappropriate** levels of inattention, hyperactivity, and impulsivity (See Table 1).[1,7,16] However, the impairment that results from ADHD can be much more profound than these observable characteristics suggest.[17] Brain-imaging, genetic, and other scientific studies are leading researchers to believe that a core deficit in ADHD involves the brain's "brakes" or inhibitory system, impairing the ability to self-regulate and control behavior.[3,5,17,18] A child with ADHD may, therefore, seem driven by the moment and less able to organize and control behavior to achieve future goals."[17] This core deficit disrupts executive functions thought to preside over all information processing tasks, triggering global impairment across multiple domains and affecting cognitive, social, emotional, behavioral, and motor functions necessary for success in school, work, and life.[19] As a result, functions such as working memory, organization, planning, problem-solving, motivation, social skills, emotional regulation, hindsight, foresight, insight, rule-governed behavior, volition, will power, self-discipline, and even sense of time can be affected by ADHD.[17,1,3,5,7,10,19] ADHD, therefore, puts children at risk for a variety of problems, including school failure, social rejection, antisocial behavior, substance abuse, psychiatric disorders, and involvement with the juvenile justice system.[1,5,7,18,20,21,22,23] The poor outcomes associated with undiagnosed, untreated, and under-treated ADHD "provides a strong argument for the recognition and treatment of ADHD in childhood" (p.431).[24]

*Alone, a diagnosis of ADHD from a physician is not enough to make a child eligible for services under Part B; the ADHD must adversely affect a child's educational performance.*

## Can children with ADHD be served under IDEA?

IDEA guarantees that states make available a free appropriate public education to children with disabilities in mandatory age ranges. Through its comprehensive approach to meeting children's needs; its attention to behavior as well as academics; its support for schools and parents; and its focus on the general curriculum, accountability, and results, IDEA offers new hope for eligible children with ADHD whose school performance suffers due to associated academic and behavioral problems that result in the students' needs for special education and related services.

To be eligible for special education services under IDEA, children with ADHD must be evaluated as having one or more of the impairments specified in Part B of IDEA and, because of the impairment, be found to need special education and related services.[25] Alone, a diagnosis of ADHD from a physician is not enough to make a child eligible for services under Part B; the ADHD must adversely affect a child's educational performance. Children with ADHD may be eligible for services under the following Part B categories, depending on their unique characteristics and identified educational needs:[15]

- **other health impairment.** Most children receiving special education services for ADHD alone will likely be classified as "Other Health Impaired," since the regulations implementing IDEA now list ADD and ADHD as conditions that can make a child eligible under this category.[25,26] Children with ADHD may meet eligibility criteria for the "other health impairment" category when their "heightened alertness to environmental stimuli...results in limited alertness with respect to the educational environment," impairing school performance.[27]
- **specific learning disability.** IDEA defines learning disability as a disorder in one or more of the basic psychological processes involved in understanding and using language that impairs the ability to listen, think, speak, read, write, spell, or do mathematical calculations. Children with ADHD may be eligible for special education in this category if they have coexisting learning disabilities. However, in some cases, ADHD alone could generate the type of impairment that would cause a child to meet criteria under this category[28]—especially the Inattentive Type, which has been linked

Table 1. Diagnostic Criteria for Subtypes of Attention-Deficit/Hyperactivity Disorder (ADHD)[1]

***For a diagnosis of ADHD, criteria A through E must be met.***

A. Must meet symptom threshold for ***subtypes (1) or (2) or (3).***

| Subtype | Symptoms |
|---|---|
| (1) Predominantly Inattentive Type | Six or more symptoms of inattention present for at least six months **to a degree that is maladaptive and inconsistent with developmental level**<br><br>***Inattention***<br>• often fails to give close attention to details or makes careless mistakes<br>• often has difficulty sustaining attention<br>• often does not seem to listen when spoken to directly<br>• often does not follow through on instructions and fails to finish work<br>• often has difficulty organizing tasks and activities<br>• often avoids dislikes or is reluctant to engage in tasks that require sustained mental effort<br>• often loses things necessary for tasks or activities<br>• often easily distracted by extraneous activities |
| (2) Predominantly Hyperactive-Impulsive Type | Six or more symptoms of hyperactivity-impulsivity present for at least six months **to a degree that is maladaptive and inconsistent with developmental level**<br><br>***Hyperactivity***<br>• often fidgets with hands/feet or squirms in seat<br>• often leaves seat in situations where remaining seated is expected<br>• often runs about or climbs excessively when inappropriate to do so (in teens or adults, may be limited to subjective feelings of restlessness)<br>• often has difficulty playing or engaging in leisure activities quietly<br>• is often "on the go" or often acts as if "driven by a motor"<br>• often talks excessively<br><br>***Impulsivity***<br>• often blurts out answers before questions have been completed<br>• often has difficulty awaiting turn<br>• often interrupts or intrudes on others (e.g., butts into conversations or games) |
| (3) Combined Type | Six or more symptoms of inattention **and** six or more symptoms of hyperactivity-impulsivity present for at least six months **to a degree that is maladaptive and inconsistent with developmental level** |

B. Some symptoms caused impairment ***before age seven***.

C. Some impairment present in ***two or more settings*** (e.g., home and school).

D. There must be ***clear evidence of clinically significant impairment*** in social, academic, or occupational functioning.

E. Symptoms are ***not better accounted for by other disorders***.

1. Adapted from the *Diagnostic and Statistical Manual of Mental Disorders (Fourth Edition)*. (1994). Washington, DC: American Psychiatric Association.

to deficits in mathematics and sensory information processing.[29] Minimal brain dysfunction, a condition listed under this category, was in fact the term for ADHD during most of the 1960s. Recent brain-imaging studies and current understanding about ADHD's effect on executive functions (and hence on information processing) also underscore this category's continued relevance.[5,5,17,18,20,28]

- **emotional disturbance.** Children with ADHD sometimes have coexisting emotional and mental disorders such as bipolar disorder, behavior disorders, anxiety disorders, or depression, that can adversely affect educational performance and make them eligible for special education services.[20,21,22,30,31,32,33] Characteristics of emotional disturbance under Part B include (1) an unexplained inability to learn or to form and maintain satisfactory relationships with teachers and peers, (2) inappropriate behavior and feelings, (3) general depression, and (4) physical symptoms or fears resulting from personal or school problems.[34]

*. . . children with disabilities who are determined not to be eligible for special education services under IDEA may still be protected and served under two other federal laws . . .*

- **developmental delay.** IDEA offers a noncategorical option—developmental delay—for children aged 3 through 9 who exhibit delays in physical, cognitive, communication, emotional, social, or adaptive development. At the discretion of the state and local educational agencies, schools can use this option to serve children within the specified age range who need special education and related services because of such delays.[35] Children with ADHD often seem immature for their age—lagging behind peers up to 30 percent—and have been found to score below average on tests used to identify developmental delays.[5,7,36,37] These results are consistent with neurological findings that are leading researchers to view ADHD as neurodevelopmental disorder.[5,7] Some functional areas in which delays are evident include socialization, communication, daily living, and self-control.[7,37] Social failure is so prevalent with ADHD that it is considered to be characteristic of the disorder.[38]

Policymakers should be aware that children with disabilities who are determined not to be eligible for special education services under IDEA may still be protected and served under two other federal laws: Section 504 of the Rehabilitation Act of 1973 (Section 504) and the Americans with Disabilities Act of 1990 (ADA). The Office for Civil Rights in the U. S. Department of Education enforces the provisions of Section 504 and Title II of the ADA with respect to school districts, while the Department of Education administers IDEA.

## Who has responsibility for seeing that schools comply with IDEA?

Under IDEA, state education agencies (SEAs) must exercise general supervision over all programs for children with disabilities administered within the state and have ultimate responsibility for ensuring that a free appropriate public education is made available to eligible disabled students. They may choose to do this one of three ways: by providing services directly, by contracting for services, or by delegating responsibility to local education agencies (LEAs). Usually, LEAs have the direct responsibility to implement state and federal regulations and to ensure that an appropriate education is provided to a child, as described in a child's individualized education program (IEP). However, if the LEA fails to do so, states must assume this responsibility, either directly or through contracts with others.

"To ensure that educators and parents have the necessary tools to improve educational results for children with disabilities," Congress added several new requirements that states must meet to be eligible for Part B of IDEA funds.[39] To receive these funds, SEAs must demonstrate to the U. S. Secretary of Education that policies and procedures are in place to ensure that these requirements are met (See Table 2).[40]

## How do the requirements apply to public agencies in meeting the education needs of children with ADHD?

To meet IDEA's new eligibility requirements under Part B for children with ADHD, states must ensure that schools (1) locate, identify, and evaluate children disabled—or suspected of being disabled—by ADHD in public and private schools (including parochial schools); (2) make available a free appropriate public education to eligible children with ADHD; (3) develop and implement an IEP designed to meet the child's educational needs, and consider, if appropriate, the child's need for positive





COPY AVAILABLE

## Table 2. State Eligibility Requirements[1]

To be eligible for assistance under Part B of IDEA, states must have policies and procedures in place to ensure that

- a free appropriate public education (FAPE) is made available to all disabled children in mandatory age ranges, including those who are suspended or expelled from school;
- a goal is established to provide full educational opportunity to all children with disabilities aged birth through 21;
- children with disabilities who attend public and private (including parochial) schools are located, identified, and evaluated to determine if they have disabilities and need special education and related services;
- an individualized education program (IEP) is developed and implemented for children with disabilities and for children aged three through five–or, at the discretion of the state education agency (SEA) a 2-year-old child with a disability who will turn age 3 during the school year–an individualized family service plan, in lieu of an IEP, if agreed to by the child's parent and the agency and if consistent with state law;
- children with disabilities are educated with nondisabled children in regular classrooms (the least restrictive environment) to the maximum extent appropriate;
- children and parents' rights are protected by procedural safeguards, including providing testing and evaluation materials and procedures that are free from cultural or racial bias;
- evaluations use a variety of tools and assessment strategies to determine if a child has a disability and to assess the child's educational needs;
- confidentiality of any personally identifiable information that is collected, used, or maintained under Part B of IDEA is protected;
- children receiving early intervention services under Part C who will participate in preschool programs assisted under Part B have a smooth transition to those programs;
- provision is made for providing special education and related services to children with disabilities in private (including parochial) schools, consistent with their numbers and location in the state;
- all educational programs and services for children with disabilities, including programs and services provided by other agencies, are under the general supervision of the persons in the SEA responsible for the education of children with disabilities;
- interagency agreements and coordination are established between the SEA and noneducational public agencies so that services needed to ensure a FAPE are provided;
- local education agencies are provided notice and a hearing before states can rule them to be ineligible for special education funds;
- a comprehensive system of personnel development is in place to ensure an adequate supply of qualified special education, regular education, and related services personnel;
- standards are established and maintained to ensure that personnel necessary to carry out the purposes of IDEA are appropriately and adequately prepared and trained;
- performance goals and indicators are established for children with disabilities consistent, to the maximum extent appropriate, with other goals and standards established by the State for all children in regular education and that indicators, at a minimum, address the performance of children with disabilities on assessments, drop-out rates, and graduation rates;
- children with disabilities are included in general state and district-wide assessment programs with appropriate accommodations, where necessary;
- Part B of IDEA funds are used to supplement the level of federal, state, and local funds expended for special education and related services for children with disabilities, and in no case to supplant those federal, state, and local funds;
- the State will not reduce state financial support for special education and related services;
- opportunities exist for public hearings and comments available to the general public, including individuals with disabilities and parents of children with disabilities, before policies and procedures related to compliance with the requirements of Part B of IDEA are adopted;
- a state advisory panel comprised of a majority of individuals with disabilities and/or their parents is established to provide guidance on policy matters related to special education and related services for children with disabilities; and
- the State examines data to determine if significant discrepancies are occurring in the rate of long-term suspension and expulsion for children with disabilities among LEAs in the state, as compared to the rates for nondisabled children in those agencies.

1. IDEA §612 and 34 C.F.R. §300.110-§300.284 (Subpart B–State and Local Eligibility)

behavioral interventions for behavior that impedes the child's learning or that of others; (4) involve parents in decisions about evaluation, eligibility, placement, and IEPs; (5) educate children with ADHD with nondisabled children in the regular education environment to the maximum extent appropriate; (6) afford eligible children and their parents the procedural safeguards outlined in IDEA; (7) ensure that professional personnel that provide special education and related services to children with ADHD meet applicable state qualification standards; (8) include children with ADHD in state performance goals; (9) include children with ADHD in general state and district-wide assessments with appropriate accommodations and modifications, where necessary; and (10) monitor suspension and expulsion rates for children receiving special education services, including those with ADHD, as compared to rates for nondisabled children. The remainder of this paper briefly discusses each requirement as it might apply to children with ADHD, to serve as a general guideline for state and local policymakers as they monitor implementation of the law.

***IEPs must now include a description of the child's present level of performance and how the disability affects involvement and progress in the general curriculum; . . . the modifications needed for participation in state and districtwide assessments; and, for older students, transition services and interagency linkages.[47]***

1. **Locate, identify, and evaluate.** The "child find" provisions of IDEA require states to locate, identify, and evaluate children with disabilities in public and private (including parochial) schools.[41] (Evaluation requirements are separate, although a part of child find. Law and regulations contain separate evaluation and child find sections, and meeting those sections is a separate eligibility criterion.) Evaluations must be comprehensive and address all areas of suspected disability and identify all service needs–assessing cognitive, behavioral, social, emotional, physical, and developmental factors, as well as the child's performance in the general curriculum, as a basis for developing the IEP.[42] Policymakers need to make sure that teachers are trained to recognize children who may be disabled by ADHD; that school evaluations are comprehensive enough to identify other conditions associated with ADHD, such as cognitive, emotional, behavioral, and mental health disorders; and that schools guard against racial and cultural bias in the evaluation process.

2. **Availability of a free, appropriate public education.** States and school districts must make a free appropriate public education (FAPE) available to children with disabilities in mandatory age ranges, including those who are suspended and expelled from school.[43] IDEA is now focused on high expectations and results for children with disabilities, ensuring their appropriate involvement and progress in the general curriculum; their education and participation in regular education classrooms with other disabled and nondisabled children; their participation in extracurricular and other non-academic activities; their participation in general state and district wide assessments—with appropriate accommodations and modifications as necessary; and their inclusion in school improvement efforts and measures of school accountability.[44] Since ADHD can cause global impairment for some children, policymakers should make sure that, as necessary, school services and accommodations are designed to help children with ADHD make adequate academic progress; that schools provide services to children with ADHD who are suspended or expelled, beginning no later than the 11th school day of their removal in a school year; that schools do not suspend children with ADHD for more than 10 consecutive days or 10 days in a pattern for disability-related behavior; and that schools develop proactive and positive behavioral interventions and supports for those whose behavior disrupts learning, to encourage and teach appropriate behavior and to prevent the need for disciplinary actions.[45,46,47]

3. **IEP.** The purpose of the IEP is to put into place the program of instruction and services to address a child's education needs; that is, "to tailor the education to the child; not tailor the child to the education" (p.20).[48] IEPs must now include: (1) a description of the child's present levels of educational performance; (2) how the child's disability affects the child's involvement and progress in the general curriculum; (3) a statement of measurable annual education goals, including short-term objectives; (4) a statement of the special education and related services, supplementary aids and services, program modifications, or supports for school personnel to be provided to the child, or on behalf of the child, to help the child advance toward attaining the annual goals and to be



BEST COPY AVAILABLE

involved and progress in the general curriculum, and to participate in extracurricular and other nonacademic activities; (5) an explanation of the extent, if any, to which the child will **not** participate with nondisabled children in regular classes and in those activities; (6) the individual modifications in test administration needed for participation in state or district-wide assessment of student achievement; (7) how the child's progress toward the annual goals will be measured; (8) how the child's parents will be regularly informed of that progress; and (9) for older students, statements of transition needs and services, including interagency linkages.[47]

Since ADHD may cause global impairment across multiple domains for some children, policymakers should make sure that IEPs provide appropriate services and accommodations to address a child's comprehensive needs, so that disability-related issues do not impede progress toward education goals or interfere with participation in regular classrooms, the general curriculum, and other school activities. Such services might include behavioral strategies and interventions; support and training for teachers and parents; assistive technology to facilitate work completion and increase attention to assignments; travel training to help children follow schedules and move from place to place on time and without incident; counseling, anger management, and social skills instruction; and, for older children, independent living and job skills (time and money management, organizational strategies, etc.), planning for postsecondary education or training, and linkages to social, health, and juvenile justice agencies, if warranted. Since the recommended multi modal treatment for ADHD requires collaboration and close coordination among parents, physicians, and educators,[12] the new roles for parents could help promote the type of home-school partnership needed to improve outcomes for children with ADHD and could potentially reduce disagreements (and litigation) over eligibility, services, and discipline. Policymakers should make sure that schools include parents—and others whom parents believe to have knowledge or special expertise regarding the child—as members of the IEP team, and involve the parents in decisions related to identification, evaluation, educational placement, and provision of a FAPE to the child.[50]

***Policymakers should make sure that schools—through the IEP—provide both the supports to regular education teachers and other school personnel the academic and behavioral interventions needed to ensure appropriate services and placements for children with ADHD.***

**5. Least restrictive environment.** IDEA "contain(s) a presumption that children with disabilities are to be educated in regular classes"(p.17) with nondisabled children, with appropriate supplementary aids and services, unless "the nature or severity of the disability...is such that education in regular classes with the use of supplementary aids and services cannot be achieved satisfactorily"(p. 10)[48,51] In such cases, schools still must offer a continuum of alternative placements designed to meet the child's unique needs (e.g., special classes, special schools, home instruction, and instruction in hospitals and institutions).[48] Policymakers should make sure that schools—through the IEP—provide both the supports to regular education teachers and other school personnel the academic and behavioral interventions needed to ensure appropriate services and placements for children with ADHD.

6. **Procedural safeguards.** IDEA's procedural safeguards are designed to protect children and parents' rights regarding matters relating to identification, evaluation, educational placement, or the provision of FAPE and to ensure parents' participation.[52] Schools must provide parents a copy of the procedural safeguards at the initial referral for evaluation, at subsequent reevaluations, and upon notification of IEP meetings. They must also provide parents with information about any available free or low-cost legal and other relevant services when due process hearings are initiated or if parents request such information.[53] Since protections under IDEA may extend even to children not yet receiving special education services, policymakers should make sure that schools identify and evaluate all children whom they suspect may have a disability, including children suspected of having ADHD—especially those who are repeatedly disciplined for disruptive, impulsive, or seemingly immature or irresponsible behavior.

7. **Qualified personnel.** IDEA's requirements that disabled students be involved and progress in the general curriculum, and be educated, to the maximum extent appropriate, in regular education classrooms with appropriate supplementary aids and services, make it imperative



BEST COPY AVAILABLE

for all teachers to become knowledgeable about how to educate all students. Since studies show that few teachers and few schools know how to appropriately educate and serve children with ADHD,[54] policymakers should make sure that preservice teacher preparation programs and in-service professional development programs train teachers to use a variety of instructional and behavioral strategies to help children with ADHD succeed in the classroom. In addition, because increasing numbers of school-age children are being prescribed medication for ADHD and other disorders, they should also make sure that states and districts have policies and procedures in place for storing and administering prescribed medications at school, and that teachers and other school personnel know and follow them.

8. **Performance goals**. To improve student results, IDEA requires states to establish a system of performance goals and indicators for children with disabilities that is consistent with goals and indicators for nondisabled students and to report students' progress in meeting the goals, including—at a minimum—their assessment results as well as their graduation and dropout rates.[55] Because children with ADHD, as a whole, have high failure and dropout rates and some may perform poorly on assessments,[56,57,58] policymakers must make sure that schools monitor performance data to assess the effectiveness of interventions, accommodations, and services, modifying services if necessary to improve results for students with ADHD.

9. **Assessment**. Children with disabilities must be included in general state and district-wide assessments, with appropriate accommodations and modifications where necessary, and results must be disaggregated and reported to the public. Accommodations and modifications allowed for testing should parallel those provided for instruction and must be included in the student's IEP. So that students' test scores accurately reflect what they know, policymakers should make sure that schools provide any needed and appropriate changes in setting, scheduling, timing, presentation format, or response format when testing children with ADHD; for example, a separate testing room, scheduling that coincides with medication dosage, extended time allotments, oral administration, marking answers in test booklets, reminders to stay on-task, or instruction in test-taking skills.[44,59]

10. **Suspension and expulsion**. States must now monitor long-term suspension and expulsion rates among LEAs in the state to determine if rates for children with disabilities are disproportionate when compared to rates for nondisabled children. If discrepancies are identified, states must review and, if appropriate, revise policies, procedures, and practices that could be contributing to the discrepancies, including those relating to development and implementation of IEPs, use of behavioral interventions, and procedural safeguards.[60] Children with ADHD, as a whole, have unusually high suspension and expulsion rates,[61] raising questions about whether they are receiving appropriate services and supports or being improperly disciplined for disability-related behavior. To help prevent the need for disciplinary action and address disproportionate rates of suspension and expulsion, policymakers should make sure that schools assess social, emotional, and behavioral factors as part of the comprehensive initial evaluation and reevaluations for children with ADHD and develop appropriate, proactive behavioral interventions for the IEP.

***. . . policymakers should make sure that schools assess social, emotional, and behavioral factors as part of the comprehensive initial evaluation and reevaluations for children with ADHD and develop appropriate, proactive . . . interventions . . .***

## How have changes to IDEA affected services to children with ADHD in AEL's region?

In response to the U. S. Department of Education's 1991 Policy Clarification Memorandum regarding children with ADD and ADHD, the four states in AEL's region—Kentucky, Tennessee, Virginia, and West Virginia—undertook efforts to see that children with ADHD received appropriate education services, such as notifying district and school administrators; adding ADD and ADHD to language in state policies governing special education; and developing materials and conducting training for regular and special educators. As a result, IDEA 1997 has not substantially altered services to children with ADHD in the region, except as changes in the law have affected services to **all** children with disabilities.

A nationwide increase in the number of children receiving special education services in the Other Health

Impairment category is evidenced in the region's state data as well (See Table 3). Some speculate that the increase is attributable to ADHD, but since IDEA does not require states to report the incidence of specific conditions within eligibility categories, most states do not have the information to make that determination. However, the large increases between 1987/88 and 1996/97 may reflect states' responses to the Policy Clarification Memorandum, which addressed, among other matters, state and schools' responsibilities under IDEA to locate, identify, and evaluate children suspected of having ADHD and to provide eligible children a FAPE to meet their education needs.[52]

**Kentucky.** Because Kentucky's education reform initiative shares IDEA's emphasis on the participation of students with disabilities in the general curriculum and school accountability measures, many of IDEA's requirements have been in place for some time for children with ADHD. The Kentucky Department of Education's training programs and publications on academic and content standards include information on instructional strategies, accommodations, and modifications that allow students with disabilities, including ADHD, to access and be part of the general curriculum. In addition, the Department has launched a major behavioral initiative, has developed a behavior website, and has cosponsored annual conferences on both behavior and exceptionalities. During its last session, the state legislature adopted IDEA's definition of developmental delay as an option for serving children aged 3 through 8.

**Tennessee.** In August 1999, the Tennessee Department of Education sponsored one-day workshops on ADHD at three locations across the state. Led by experts from Vanderbilt University, the workshops were designed to inform regular education teachers about issues related to ADHD, including identification, evaluation, medication, parent training, social skills, and proactive classroom strategies, as well as behavior assessment, management, and interventions. Tennessee has also adopted IDEA's definition of developmental delay.

**Virginia.** As a follow-up to previous statewide efforts resulting from its 1989 Task Force Report on ADHD, the Virginia Department of Education is developing a new publication on ADHD to provide school divisions with updated information and resources. An ADHD authority at the University of Virginia, who assisted the Department with the earlier work, is helping to spearhead the project.

In 1997, the Department issued a memorandum that allows LEAs to serve children aged 5 through 9 under an existing state definition of developmental delay, until the revised special education regulations are issued later in the year 2000. At the recommendation of special education stakeholders, the definition in proposed regulations includes children aged 5 through 8.

**West Virginia.** The West Virginia Department of Education has conducted two rounds of statewide training for teachers—one focused on IDEA 1997 and the other on newly revised state regulations for special education. Both trainings addressed the addition of ADHD to the OHI category of Part B. West Virginia has not adopted the term developmental delay, but serves children aged 3 through 5 under the nearly identical definition of preschool special needs.

Table 3. Number and Change in Number of Children Ages 6-21 Served Under IDEA, Part B

| | Other Health Impairments | | | | | | |
|---|---|---|---|---|---|---|---|
| State/Nation | Number Served | | | Change in Number Served | | % Change in Number Served | |
| | 1987/88 | 1996/97 | 1997/98 | 87/88-97/98 | 96/97-97/98 | 87/88-97/98 | 96/97-97/98 |
| Nation | 46,013 | 161,155 | 190,935 | 144,922 | 29,780 | 314.96 | 18.48 |
| Kentucky | 278 | 2,336 | 3,404 | 3,126 | 1,068 | 1,124.46 | 45.72 |
| Tennessee | 1,740 | 8,339 | 8,951 | 7,211 | 612 | 414.43 | 7.34 |
| Virginia | 486 | 5,904 | 7,713 | 7,227 | 1,809 | 1,487.04 | 30.64 |
| West Virginia | 88 | 1,011 | 1,353 | 1,265 | 342 | 1,437.50 | 33.83 |

Source: 21st Annual Report to Congress: 1999. Table AA9. Washington, DC: U. S. Department of Education, Office of Special Education Programs. Available: http://www.ed.gov/offices/OSERS/OSEP/index.html.

## Summary

IDEA's new emphasis on achieving results holds promise for children with ADHD, whose needs have often been ignored or inappropriately addressed by schools. By comprehensively assessing and addressing their needs; involving and supporting their parents and teachers; and expecting their participation in the general curriculum, regular classrooms, assessments, and accountability and performance goals, IDEA should bring about improved outcomes for children with ADHD.

Because state and local policymakers are responsible for overseeing public education and for ensuring that schools make a free appropriate public education available to children with disabilities, state education agencies and education policymakers have a clear mandate to monitor the implementation of special education policies and laws. So that the promise of the 1997 Amendments to IDEA as well as state and district education goals are realized for children with ADHD, they also must be sure that the laws and policies are known and implemented in their schools.

## Notes


1. Goldman, L., Genel, M., Bezman, R., & Slanetz, P., for the Council on Scientific Affairs of the American Medical Association. (1998). Council report: Diagnosis and treatment of Attention-Deficit/Hyperactivity Disorder in children and adolescents. *Journal of the American Medical Association, 279* (14) 1100-1107.

2. Barkley, R. (1998). Gene linked to ADHD verified. *The ADHD Report, 6* (3), pp. 1- 5.

3. Swanson, J., Castellanos, X., Murias, M., LaHoste, G., & Kennedy, J. (1998). Cognitive neuroscience of attention deficit hyperactivity disorder and hyperkinetic disorder. *Current Opinion in Neurobiology, 8*, pp. 263-271.

4. Swanson, J., Sunohara, G., Kennedy, J., Regino, R., Fineberg, E., Wigal, T., Lerner, M., Williams, L. LaHoste, G., & Wigal, S. (1998). Association of the dopamine receptor D4 (DRD4) gene with a refined phenotype of attention deficit hyperactivity disorder (ADHD): A family-based approach. *Molecular Psychiatry, 3*, pp. 38-41.

5. Castellanos, X. (1997, July). Toward a pathophysiology of Attention-Deficit/Hyperactivity Disorder. *Clinical Pediatrics*, pp. 381-393.

6. Busch, B. (1993). Attention deficits: Current concepts, controversies, management, and approaches to classroom instruction. *Annals of Dyslexia, 43*, pp. 5-25.

7. Barkley, R. (1995). *Taking charge of ADHD*. New York: The Guilford Press.

8. Swanson, J. (1992). *School-based assessments and interventions for ADD students*. Irvine, CA: K. C. Publishing.

9. Fiore, T., Becker, E., & Nero, R. (1993). Research synthesis on education interventions for students with attention deficit disorder. *Education of children with attention deficit disorder*. Washington, DC: U. S. Department of Education.

10. Dulcan, M., and the Work Group on Quality Issues. (October, 1997). AACAP Official Action: Practice parameters for the assessment and treatment of children, adolescents, and adults with attention-deficit/hyperactivity disorder. *Journal of the American Academy of Child and Adolescent Psychiatry, 36*(10), Supplement.

11. Gregg, S. (1995). *Policy briefs: ADHD–Building academic success*. Charleston, WV: Appalachia Educational Laboratory.

12. Wolraich, M. (1997). Parents, teachers, & physicians: Working together to provide optimal care for children with ADHD. *Attention, 4* (1), pp.28-29.

13. Barkley, R. (1981). *Hyperactive children: A handbook for diagnosis and treatment*. New York: The Guilford Press.

14. 34 CFR §300.125.

15. Davila, R., Williams, M., & MacDonald, J. (1991). *Memorandum to chief state school officers re: Clarification of policy to address the needs of children with attention deficit disorders within general and/or special education*. Washington, DC: U. S. Department of Education.

16. American Psychiatric Association. (1994). *Diagnostic and statistical manual of mental disorders*. (4th ed.). Washington, DC: Author.

17. Barkley, R. (1997). *ADHD and the nature of self-control*. New York, NY: The Guilford Press.

18. Castellanos, X. (1997). Approaching a scientific understanding of what happens in the brain in ADHD. *Attention, 4* (1), pp. 30, 31, 34, 35, 43.

19. Pennington, B. (1991). *Diagnosing learning disorders: A neuropsychological framework*. New York, NY: The Guilford Press.

20. Dykman, R., Ackerman, P., & Raney, T. (1993). Assessment and characteristics of children with attention deficit disorder. *Education of children with attention deficit disorder*. Washington, DC: U. S. Department of Education.

21. McKinney, J., Montague, M., & Hocutt, A. (1993). A synthesis of the research literature on the assessment and identification of attention deficit disorder. *Education of children with attention deficit disorder*. Washington, DC: U. S. Department of Education.

22. Biederman, J., Faraone, S., Milberger, S., Guite, J., Mick, E., Chen, L., Mennin, D., Marrs, A., Ouellette, C., Moore, P., Spencer, T., Wilens, T., Kraus, I., & Perrin, J. (1996). A prospective 4-year follow-up study of attention-deficit hyperactivity and related disorders. *Archives of General Psychiatry, 53* (5), pp. 437-446.

23. Gregg, S. (1996). *Policy briefs: Preventing antisocial behavior in disabled and at-risk students*. Charleston, WV: Appalachia Educational Laboratory.

24. Swanson, J., Sergeant, J., Taylor, E., Sonuga-Barke, E., Jensen, P., & Cantwell, D. (1998). Attention-deficit hyperactivity disorder and hyperkinetic disorder. *The Lancet, 351*, pp. 429-434.

25. IDEA §602(3).

26. 34 CFR §300.7(c)(9)(i).

27. 34 CFR §300.7(c)(9).

28. Latham, P. S., & Latham, P. H. (1992). *Attention deficit disorder and the law*. Washington, DC: JKL Communications.

29. Carlson, C., Shin, M., & Booth, J. (1999). The case for DSM-IV subtypes in ADHD. *Mental Retardation and Developmental Disabilities, 5*(3), 199-206.

30. Biederman, J., Faraone, S., Mick, E., Wozniak, J., Chen, L., Ouellette, C., Marrs, A., Moore, P., Garcia, J., Mennin, D., & Lelon, E. (1996). Attention-deficit disorder and juvenile mania: an overlooked comorbidity? *Journal of the American Academy of Child and Adolescent Psychiatry, 35* (8), pp. 997-1008.

31. Wozniak, J., & Biederman, J. (1994). Prepubertal mania exists (and coexists with ADHD). *ADHD Report, 2* (3), pp. 5-6.

32. Faraone, S., Biederman, J., Wozniak, J., Mundy, E., Mennin, D., & O'Donnell, D. (1997). Is comorbidity with ADHD a marker for juvenile-onset mania? *Journal of the American Academy of Child and Adolescent Psychiatry, 36* (8), pp. 1046-1055.

33. Pliska, S. (1999). Bipolar disorder and ADHD: Comments on the current controversy. *ADHD Report, 7*(1), pp. 9-11.

34. 34 CFR §300.7(c)(4)(i).

35. IDEA §602(3)(B)(i) and 34 CFR §300.7(b).

36. Sparrow, S., Balla, D., & Cicchetti, D. (1985). *Vineland Adaptive Behavior Scales.* Circle Pines, MN: American Guidance Service, Inc.

37. Stein et al., as cited in Research findings. (1995). *The ADHD Report, 3*(5), p. 14.

38. Landau, S., & Moore, L. (1991). Social skills deficits in children with attention-deficit hyperactivity disorder. *School Psychology Review, 20* (2), 235-251.

39. IDEA §601(d)(3).

40. IDEA §612.

41. IDEA §612(a)(3) and 34 CFR §300.125.

42. 34 CFR §300.532.

43. IDEA §612(a)(1)(A).

44. Yell, M. & Shriner, J. (1997). The IDEA Amendments of 1997: Implications for special and general education teachers, administrators, and teacher trainers. *Focus on Exceptional Children, 30*(1), 1-19.

45. 34 CFR §300.121(d).

46. 34 CFR §300.519.

47. IDEA §615(K)(1)(B) and 34 CFR §300.520(b)(1)(ii).

48. Senate Comm. on Labor and Human Resources, Individuals with Disabilities Education Act of 1997, S. Rep. (to accompany S. 717) No. 46, 105th Cong., 1st Sess. (1997), 105-17. Available: http://www.lrp.com/ed/useftp.htm.

49. IDEA §614(d) and 34 CFR §300.347.

50. 34 CFR § 300.501.

51. IDEA §612(a)(5)(A) and 34 CFR §300.550.

52. Tucker, B. P., & Goldstein, B. A. (1992). *Legal rights of persons with disabilities: An analysis of federal law.* Horsham, PA: LRP Publications.

53. 34 CFR §300.504 and §300.507(a)(3).

54. Hawkins, J., Martin, S., Blanchard, K., & Brady, M. (1991). Teacher perceptions, beliefs, and interventions regarding children with attention deficit disorders. *Action in Teacher Education, XIII* (2), pp. 52-59.

55. IDEA §612(a)(16)(B) and 34 CFR §300.137.

56. Barkley, R. (1998, October 17). *Young adult outcomes of hyperactive children.* Paper presented at the annual conference of Children and Adults with Attention-Deficit Hyperactivity Disorder (CHADD), New York, NY.

57. Ingersoll, B. (1998). *Your hyperactive child.* New York, NY: Doubleday.

58. Langenfeld, K., Thurlow, M., & Scott, D. (1997). *High stakes testing for students: Unanswered questions and implications for students with disabilities, synthesis report 26.* Minneapolis: University of Minnesota, National Center for Educational Outcomes.

59. Ysseldyke, J., & Thurlow, M. (1999). Including students with disabilities in statewide assessments and accountability systems. Washington, DC: National Governors' Association.

60. IDEA §612(a)(22) and 34 CFR §300.146.

61. Fowler, M. (1992). *CHADD educator's manual.* Landover, MD: CHADD.

62. Davila, R., Williams, M., & MacDonald, J. (1991). *Memorandum to chief state school officers re: Clarification of policy to address the needs of children with attention deficit disorders within general and/or special education.* Washington, DC: U. S. Department of Education.


### State Contacts:

KY-Nancy LaCount 502/564-2672
TN-Linda Vandermeer 615/741-3340
VA-Harley Tomey 804/371-8283
WV-Sandra McQuain 304/558-2696

### IDEA Resources:

IDEA Policymaker Partnership
http://www.ideapolicy.org

U. S. Department of Education
http://www.ed.gov/offices/OSERS/IDEA

### ADHD Resources:

Children and Adults with Attention-Deficit/Hyperactivity Disorder (CHADD). http://www.chadd.org

National Institutes of Health
http://www.nimh.nih.gov/publicat/adhd.htm

### Behavior and Discipline Resources:

AEL http://www.ael.org/rel/policy/adhd4.htm

Center for Effective Collaboration and Practice
http://www.air-dc.org/cecp/fba/default.htm

CHADD http://www.chadd.org/papers/school_discipline1.htm

Kentucky Department of Education Behavior Webpage
http://www.state.ky.us/agencies/behave/homepage.html

National Association of School Psychologists http://www.naspweb.org/pdf/BehInt2k.pdf

### Instructional Resources:

AEL http://www.ael.org/rel/policy/adhd3.htm
CHADD http://www.chadd.org/facts/add_facts06.htm
Kentucky Department of Education Diversity Heights Village http://www.diversity.fayette.k12.ky.us
LDOnline http://www.ldonline.org




BEST COPY AVAILABLE

## Additional AEL Policy Publications

Additional recent ***Policy Briefs***, publications for those interested in educational policy, may be obtained from AEL by calling the AEL Distribution Center at (304) 347-0400 or e-mailing the AEL Resource Center at aelinfo@ael.org. In addition, the publications can be downloaded from the Policy Services web pages at: http://www.ael.org/rel/policy/polbrief.htm.

| TITLE | DATE |
|---|---|
| *The Science of Evolution: Educational Policy for the Twenty-first Century* | 2000 |
| *Charter Schools: The Perspective from AEL's Region* | 1999 |
| *Schools for Disruptive Students: A Questionable Alternative* | 1998 |
| *School-Based Programs to Promote Safety and Civility* | 1998 |
| *The Telecommunications Act of 1996: A Guide for Educators* | 1997 |

This issue of *Policy Briefs* was exerpted from a monograph, *ADHD and School Law*, which can be found on AEL's website at http://www.ael.org. Both publications were researched and written by Soleil Gregg, AEL staff.

This publication may be reproduced and distribu
request, AEL will provide a camera-ready copy

**AEL, Inc.**
PO Box 1348
Charleston, WV
25325-1348

**Address Correction Requested**

Telephone:
304-347-0400
800-624-9120
304-347-0487 Fax
aelinfo@ael.org
www.ael.org

AEL is a private, nonprofit corporation. AEL's mission is to link the knowledge from research with the wisdom from practice to improve teaching and learning. AEL serves as the Regional Educational Laboratory for Kentucky, Tennessee, Virginia, and West Virginia. For these same four states, it operates both a Regional Technology in Education Consortium and the Eisenhower Regional Consortium for Mathematics and Science Education. In addition, it serves as the Region IV Comprehensive Center and operates the ERIC Clearinghouse on Rural Education and Small Schools. AEL's primary source of funding is the Office of Educational Research and Improvement (OERI), U.S. Department of Education. This publication is produced with funds from OERI contract number RJ96006001. The contents herein do not necessarily reflect the policies or views of AEL, OERI, or the Department.

**AEL is an equal opportunity/affirmative action employer**

BEST COPY AVAILABLE